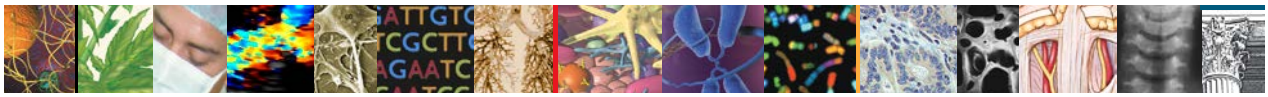

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Perspective

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Predicting the Fallout from *King v. Burwell* — Exchanges and the ACA

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The U.S. Supreme Court's surprise announcement on November 7 that it would hear *King v. Burwell* struck fear in the hearts of supporters of the Affordable Care Act (ACA). At stake is the legality of an Internal Revenue Service (IRS) rule extending tax credits to the 4.5 million people who bought their health plans in the 34 states that declined to establish their own health insurance exchanges under the ACA.[1] The case hinges on enigmatic statutory language that seems to link the amount of tax credits to a health plan purchased "through an Exchange established by the State." According to the plaintiffs in *King*, that language means that consumers who buy insurance through federally run exchanges don't qualify for subsidies. The Court's decision to hear the case without a split between appellate courts suggests that at least four justices harbor serious doubts about the IRS rule's validity.

Not long after the announcement, however, some voices began questioning whether a decision in *King* invalidating the rule would matter all that much. Those voices included both proponents of the litigation trying to minimize the chaos it would cause and financial advisors hoping to calm jittery investors. They have argued that the states that refused to create exchanges would, under intense political pressure to restore large tax credits to middle-class citizens, move quickly to do so, and the Department of Health and Human Services (HHS) would help them by relaxing any applicable rules.

We are not so optimistic. If the IRS rule is invalidated — and absent effective contingency planning — a state that has declined to create its own exchange probably won't be able to stave off the immediate destabilization of its insurance market. The Court will probably release its opinion in late June; its decision will take effect 25 days later. At that point, if the challengers prevail, the U.S. Treasury will probably have to stop issuing tax credits to users of federal exchanges. Enrollees who are unable or unwilling to pay the full cost of their insurance premiums could see their coverage terminated, perhaps as soon as 30 days after they fail to make a

payment. Those who retain insurance are likely to be sicker than those who drop coverage, which will skew the risk pools and expose insurers to large, unanticipated losses.

Picking up the pieces would not be easy. An exchange is not just a website, and setting one up requires a sizable investment of time and resources. Under the ACA, an exchange must be a government or nonprofit entity with the capacity, among other responsibilities, to consult with stakeholders, grant exemptions from the individual mandate to obtain health insurance coverage, operate a program that helps people navigate the system, and certify, recertify, and decertify qualified health plans.

To avoid the technological challenges that initially dogged HealthCare.gov, states could delegate some responsibilities to the private contractors that run the federal exchanges. Idaho, for example, established its own exchange — a quasi-governmental organization with an 18-member board — even as it used the federal website to process 2014 enrollments.[2] Whether a state-established exchange could be an empty shell, with all its functions delegated to the federal marketplace, is much less clear.

Recognizing the difficulties involved in shifting from federal to state exchanges, some observers believe that HHS might deem the seven states with "partnership exchanges" — federally established exchanges partly operated by the states — to have "established" their own exchanges. Any such move, however, could provoke an immediate and forceful legal challenge. Because partnership exchanges were meant to provide an option to states that declined to establish their own exchanges, it would be awkward for the agency to now treat state cooperation as tantamount to establishment. Even if the move passed legal muster, changing the rules for partnership exchanges would still leave 27 states without recourse.

Other observers have suggested that states might seek "state innovation waivers" under the ACA. A waiver allows a state to sidestep certain ACA requirements — including the exchange and premium-tax-credit provisions — in favor of an alternative plan offering similarly comprehensive and affordable coverage. The federal government would then pay the state the same amount of money that its residents would have received under the ACA without a waiver. Per the ACA, however, waivers cannot take effect until 2017, which would leave long coverage gaps. Worse, if the *King* challengers prevail, people in states without their own exchanges would not be entitled to receive any money in tax credits. Arguably, then, none of that money would be payable to those states under a waiver. Although the administration might have the legal flexibility to avoid this constraint, the operative word here is "might." Any attempt to work around *King* is sure to face legal challenges, which would introduce additional uncertainty and delay.

The obstacles to state action do not end there. To ensure that state exchanges meet their obligations, HHS regulations require states to secure conditional approval at least 6.5 months before launch. By the time the Court releases its decision, the deadline for establishing a 2016 exchange will have passed. Although HHS could adjust that deadline, the states would still need to take concrete steps to establish an exchange well before the end of 2015.

Moreover, governors can act on their own only if they can identify a "clear" source of legal authority, according to an HHS blueprint for state-operated exchanges.[3] A few governors — including those of Kentucky, New York, and Rhode Island — have proceeded without legislative involvement. But not all governors in the states that declined to establish exchanges have the statutory authority to go it alone. Indeed, at least seven of those states, including Missouri and North Carolina, have flatly prohibited their governors from establishing exchanges.[4] Even governors who could identify a legal basis for moving forward would be reluctant to press ahead in the face of legislative resistance, lest they imperil the rest of their political agenda.

In most states, then, legislatures will have to put their imprimatur on state exchanges. Yet only 8 of the 34 states using the federal exchange have legislative sessions extending beyond June (see table).[5] In order to avoid a gap in financial assistance for their residents, the other 26 states would need to create an exchange during the 2015 legislative session — well before the Supreme Court is likely to rule. Otherwise, they might be unable to operate their own exchanges until 2017.

Beyond these practical constraints, the states in question may not want to operate their own exchanges. The political

Government Characteristics in 2015 and ACA-Implementation Status in States without State-Established Health Insurance Exchanges.*

State	Party of the Governor	Party That Controls the Legislature	Legislative Session Extends beyond July 1	Partnership Exchange	Medicaid Expansion	No. of People Eligible for Tax Credits in 2016†
Alabama	R	R				237,407
Alaska	R	R				32,372
Arizona	R	R			x	264,053
Arkansas	R	R		x	x	111,241
Delaware	D	D		x	x	32,645
Florida	R	R				2,545,469
Georgia	R	R				784,381
Illinois	R	D	x	x	x	479,055
Indiana	R	R				335,428
Iowa	R	Split		x	x	69,743
Kansas	R	R				127,804
Louisiana	R	R				254,477
Maine	R	Split				113,391
Michigan	R	R	x	x	x	676,026
Mississippi	R	R				164,420
Missouri	D	R				370,765
Montana	D	R				89,587
Nebraska	R	Nonpartisan				106,663
New Hampshire	D	R	x	x	x	88,072
New Jersey	R	D	x		x	388,209
North Carolina	R	R	x			926,023
North Dakota	R	R			x	25,638
Ohio	R	R	x		x	374,605
Oklahoma	R	R				156,077
Pennsylvania	D	R	x		x	736,178
South Carolina	R	R				295,186
South Dakota	R	R				33,611
Tennessee	R	R				343,415
Texas	R	R				1,750,688
Utah	R	R				209,148
Virginia	D	R				504,847
West Virginia	D	R		x	x	48,685
Wisconsin	R	R	x			361,719
Wyoming	R	R				31,643
Total			8	7	12	13,068,671

* An x indicates that the state has that characteristic or status.
† Data are from the Kaiser Family Foundation (http://kff.org/interactive/king-v-burwell).

climate is hostile to the ACA in nearly all of them. Just seven of them will be led by Democratic governors in 2015; of those governors, all but Delaware's Jack Markell will face a Republican-controlled legislature. Not all Republican governors oppose state-based insurance exchanges: both Rick Snyder of Michigan and Rick Scott of Florida have lent their support to state exchanges. In the November elections, however, the states that would have been considered most likely to establish their own exchanges (in particular, those that expanded Medicaid) either sent Republican governors to the statehouse or saw Republicans increase their margins in the legislature. Many of those Republicans campaigned on their ardent opposition to Obamacare.

Unquestionably, state officials would face enormous pressure — from taxpayers, health plans, and hospitals — to set up exchanges. In a volatile political environment, some states might well do so. But ACA opponents' commitment to resisting the temptation of federal money should not be underestimated: witness the refusal of nearly two dozen states to expand Medicaid even though the federal government would cover almost all the costs.

ACA supporters thus have good reason to worry. For at least several years, and perhaps for much longer, the outcome in *King* could determine whether millions of people continue to have access to affordable, comprehensive health insurance.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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Maintenance of Certification 2.0 — Strong Start, Continued Evolution

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An anesthesiologist inserts an intraosseous line to administer lifesaving medication, as he learned to do during a simulation exercise; office-based pediatricians collaborate to improve the care of children with asthma; family-medicine physicians improve the care of their diabetic patients. These are examples of why we became physicians and the types of outcomes we hope to see in our patients. They're also improvements in care and skills that have resulted from participation in maintenance of certification (MOC) activities. So why is MOC so controversial?

Some older physicians resent MOC's new requirements associated with the board certification they worked hard to earn years ago; some younger physicians can't understand why the requirement to prove current competence doesn't apply to colleagues who are further removed from training than they are. Some physicians argue that MOC's burdens, including time and cost, are unjustified in an era when other regulatory requirements are already unmanageable and are pulling us away from our patients. Many physicians who find value in the MOC program nevertheless propose potential improvements to its structure and delivery. There's also broad understanding that the member boards of the American Board of Medical Specialties (ABMS), in collaboration with external researchers, must ensure that the program's research base expands and its quality is continuously improved.

For many years, board certification was granted at a single point in a physician's career. Certification by one of the ABMS member boards was meant to uphold the trust-based relationship between medical professionals and patients: the profession